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BLOOMBERG SCHOOL
of PUBLIC HEALTH

Module 1: Cultural Competency: Overview and Health Disparities

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Hopkins Center for
Health Disparities Solutions

About Us



*Hopkins Center for
Health Disparities Solutions*

*“Exploration and Intervention for Health
Equality...”*



NIMHD

Designated a “National Center of Excellence”
by the National Institutes of Health,
National Institute on Minority Health and Health Disparities





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Cultural Competency: Overview



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Video Clip: Where are you from?



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NAME Exercise



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Key Concepts in Cultural Competency: **Definitions and Examples**



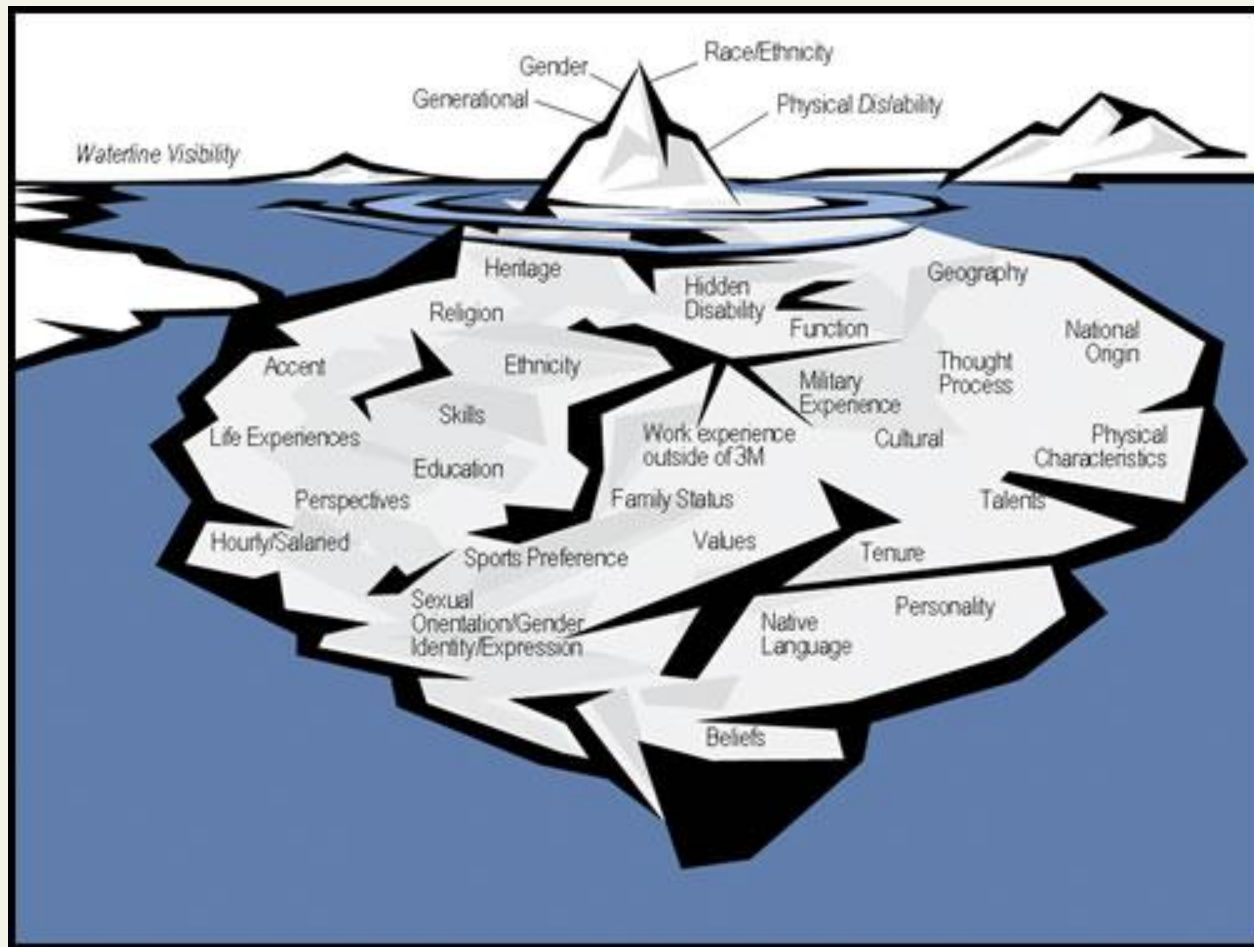
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***Culture* is an integrated pattern of human behavior which includes but is not limited to:**



**... of a racial, ethnic, religious, social, disability or political group;
ability to transmit the above to succeeding generations;
dynamic in nature.**

Iceberg Analogy of Culture



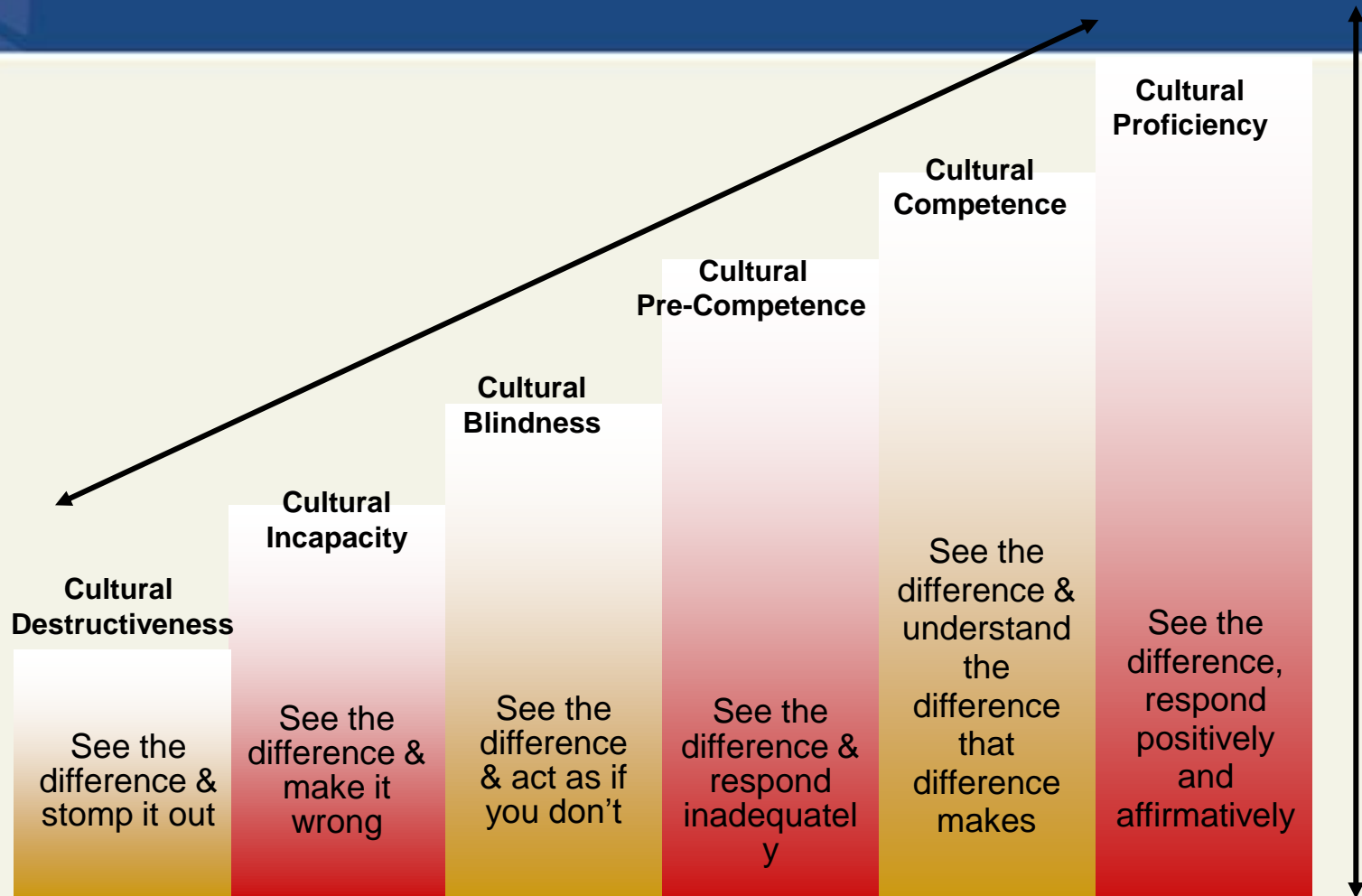
What is Cultural Competence?

- A developmental process that evolves over an extended period of time.
- Individuals, organizations, and systems are at various levels of awareness, knowledge and skills along the cultural competence **continuum**.

Source: Terry L. Cross. *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed*. Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center, 1989.

Cultural Competence Continuum

(Cross, Bazron, Dennis and Isaacs, 1989)



What is Organizational Cultural Competence?

It requires organizations to:

1. Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally;

Source: Terry L. Cross. *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed*. Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center, 1989.

What is Organizational Cultural Competence?

2. Have the capacity to:
 - (a) value diversity,
 - (b) conduct self-assessment,**
 - (c) manage the dynamics of difference,
 - (d) acquire and institutionalize cultural knowledge, and
 - (e) adapt to the diversity and cultural contexts of communities they serve;

Source: Terry L. Cross. *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed*. Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center, 1989.

What is Organizational Cultural Competence?

3. Incorporate the above into all aspects of:
 - (a) policymaking,
 - (b) administration,
 - (c) practice and service delivery,
 - (d) and systematically involve consumers, key stakeholders and communities.

Source: Terry L. Cross. *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed*. Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center, 1989.

Federal and State Legislation, Mandates, and Regulatory Standards



Federal and State Legislation, Mandates, and Regulatory Standards

- Title VI of the Civil Rights Act of 1964
- CLAS Standards (2001; Enhanced Standards, April 2013)
- NQF: *A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency* (2009)
- American Recovery and Reinvestment Act (ARRA) of 2009 and Meaningful Use of Electronic Health Records (EHRs)

Federal and State Legislation, Mandates, and Regulatory Standards

- NCQA Multicultural Health Care Standards: Distinction Program (effective 7/1/2010)
- The Joint Commission “Effective Communication, Cultural Competence, and Patient- and Family-Centered Care” Standards (effective 1/1/2011)
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Patient Experience Surveys
 - includes cultural competency and health literacy item sets
- Patient Protection and Affordable Care Act of 2010 (PPACA or ACA)

Federal and State Legislation, Mandates, and Regulatory Standards

- NCQA Patient-Centered Medical Home Recognition
- URAC Patient Centered Health Care Home Practice Achievement
- The Joint Commission Primary Care Medical Home Certification
- Accreditation Association for Ambulatory Health Care (AAAHC) Primary Care & Medical Home Accreditation

Title VI of the Civil Rights Act of 1964



THE UNITED STATES
DEPARTMENT OF JUSTICE

- Title VI of the Civil Rights Act of 1964 considers the denial or delay of medical care due to language barriers to be discrimination.
- Any medical facility receiving Medicaid or Medicare must provide language assistance to limited English proficient (LEP) patients.

Title VI of the Civil Rights Act of 1964



THE UNITED STATES
DEPARTMENT OF JUSTICE

- Not only applies to healthcare, behavioral health and social/human services organizations
- Memo from U.S. Department of Justice regarding “Providing Language Access in the Courts: Working Together to Ensure Justice” (March 11, 2014)

2013 Enhanced CLAS Standards: Principle Standard



1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

2013 Enhanced CLAS Standards: Governance, Leadership, and Workforce



2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.
3. Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

2013 Enhanced CLAS Standards: Communication and Language Assistance



5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

2013 Enhanced CLAS Standards: Engagement, Continuous Improvement and Accountability



9. Establish culturally and linguistically appropriate goals, policies and management accountability, and infuse them throughout the organizations' planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

2013 Enhanced CLAS Standards: Engagement, Continuous Improvement and Accountability



12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness.
14. Create conflict- and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.

National Quality Forum (NQF)



- “National Voluntary Consensus Standards for a Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency”
 - Published in February 2009
 - 45 best practices organized into 7 domains

National Quality Forum (NQF)



- The number of best practices associated with the domain follows in parentheses.
 1. Leadership (7)
 2. Integration into Management Systems and Operations (4)
 3. Patient-Provider Communication (10)
 4. Care Delivery and Supporting Mechanisms (6)
 5. Workforce Diversity and Training (3)
 6. Community Engagement (5)
 7. Data Collection, Public Accountability, and Quality Improvement (10)

Meaningful Use of Electronic Health Records (EHRs)



- The 2009 American Recovery and Reinvestment Act (ARRA) established the principle of meaningful use.
- The Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONCHIT) established standards for the meaningful use of electronic health records.

Meaningful Use of Electronic Health Records (EHRs)



- During stage 1 of implementation, the minimum meaningful use standards enable a user to electronically record, modify, and retrieve patient demographic data including:
 - preferred language
 - insurance type
 - gender
 - race
 - ethnicity
 - date of birth
 - date and cause of death in the event of mortality

NCQA Multicultural Health Care (MHC) Standards: Distinction Program



- 5 broad standards consisting of multiple required elements:
 - MHC 1: Race/Ethnicity and Language Data
 - MHC 2: Access and Availability of Language Services
 - MHC 3: Practitioner Network Cultural Responsiveness
 - MHC 4: Culturally and Linguistically Appropriate Services Programs
 - MHC 5: Reducing Health Care Disparities

NCQA Multicultural Health Care (MHC) Standards: Distinction Program



- Health Partners of Philadelphia, Inc.
- Kaiser Foundation Health Plan of Georgia, Inc.
- Keystone Health Plan West, Inc.
- Kaiser Foundation Health Plan Inc. - Southern California
- AmeriHealth Mercy Health Plan
- Keystone Mercy Health Plan
- Select Health of South Carolina, Inc.

Joint Commission Standards



- The Joint Commission accredits most healthcare organizations, such as:
 - Ambulatory Health Care
 - Behavioral Health Care
 - Critical Access Hospitals
 - Home Care
 - Hospitals
 - Laboratory Services
 - Long Term Care
 - International Accreditation

Joint Commission Standards



- “Effective Communication, Cultural Competence, and Patient- and Family-Centered Care” Standards
 - Effective January 1, 2011
 - Starting in 2012, failure to comply with these standards will jeopardize a healthcare organization’s accreditation status.

Joint Commission Standards



- 8 new or revised elements of performance (EPs)
 - Addressing qualifications for language interpreters and translators (revised)
 - Identifying patient communication needs (new)
 - Addressing patient communication needs (new)
 - Collecting race and ethnicity data (revised)
 - Collecting language data (revised)
 - Patient access to chosen support individual (new)
 - Non-discrimination in patient care (new)
 - Providing language services (revised)

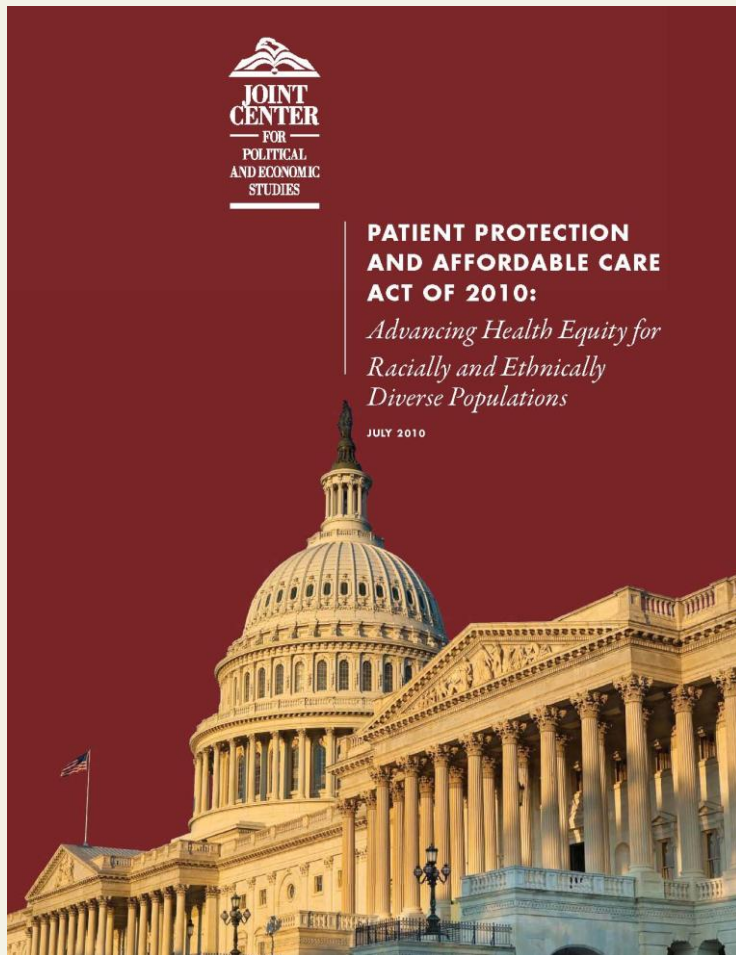
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

HCAHPS

Hospital Consumer Assessment of
Healthcare Providers and Systems

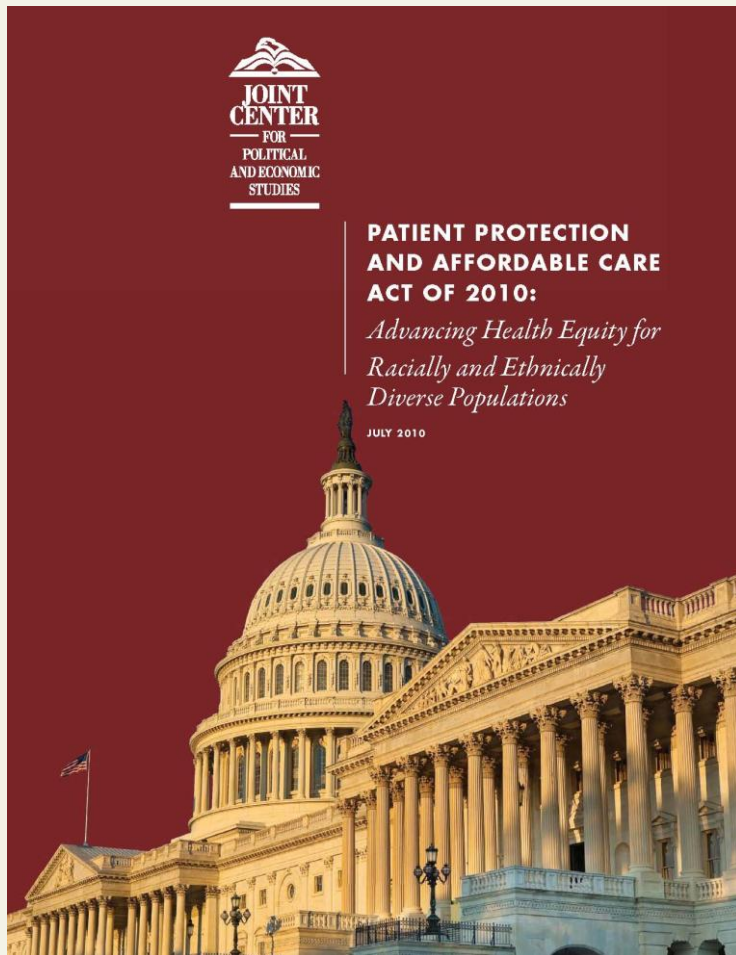
- Since July 2007, CMS has required all hospitals (except critical access hospitals) that are subject to the Inpatient Prospective Payment System (IPPS) to collect and submit patient experience data using the HCAHPS survey.
 - Note: Also does not apply to pediatric hospitals, psychiatric hospitals or other specialty hospitals.
- In the Patient Protection and Affordable Care Act of 2010, HCAHPS linked to value based purchasing (VBP).
- Penalty for non-participation (meaning not submitting quality measures including HCAHPS) equals reduction of 2% of annual payment update.

Patient Protection and Affordable Care Act of 2010 (PPACA)



- Data collection and reporting by race, ethnicity, and language
- Workforce diversity
- Cultural competence education and organizational support

Patient Protection and Affordable Care Act of 2010 (PPACA)



- Health disparities research
- Health disparities initiatives in prevention
- Addressing disparities in health insurance reforms

Sample Provisions

- Meaningful Use of Electronic Health Records
- Section 4302 of the ACA
- Section 10334 of the ACA

Section 4302 of the ACA: Race and Ethnicity Standards

Ethnicity Data Standard

Are you Hispanic, Latino/a, or Spanish origin (One or more categories may be selected)

- a. ☐ *No, not of Hispanic, Latino/a, or Spanish origin*
- b. ☐ *Yes, Mexican, Mexican American, Chicano/a*
- c. ☐ *Yes, Puerto Rican*
- d. ☐ *Yes, Cuban*
- e. ☐ *Yes, Another Hispanic, Latino/a or Spanish origin*

These categories roll-up to the Hispanic or Latino category of the OMB standard

Race Data Standard

What is your race? (One or more categories may be selected)

- a. ☐ *White*
- b. ☐ *Black or African American*
- c. ☐ *American Indian or Alaska Native*

These categories are part of the current OMB standard

- d. ☐ *Asian Indian*
- e. ☐ *Chinese*
- f. ☐ *Filipino*
- g. ☐ *Japanese*
- h. ☐ *Korean*
- i. ☐ *Vietnamese*
- j. ☐ *Other Asian*

These categories roll-up to the Asian category of the OMB standard

- k. ☐ *Native Hawaiian*
- l. ☐ *Guamanian or Chamorro*
- m. ☐ *Samoan*
- n. ☐ *Other Pacific Islander*

These categories roll-up to the Native Hawaiian or Other Pacific Islander category of the OMB standard

Section 4302 of the ACA: Gender

Sex Data Standard

What is your sex?

- a. ☐ *Male*
- b. ☐ *Female*

Section 4302 of the ACA: Primary Language

Data Standard for Primary Language

How well do you speak English? (5 years old or older)

- a. ☐ *Very well*
- b. ☐ *Well*
- c. ☐ *Not well*
- d. ☐ *Not at all*

1. Do you speak a language other than English at home? (5 years old or older)

- a. ☐ *Yes*
- b. ☐ *No*

For persons speaking a language other than English (answering yes to the question above):

2. What is this language? (5 years old or older)

- a. ☐ *Spanish*
- b. ☐ *Other Language (Identify)*

Section 4302 of the ACA: Disability Status

Data Standard for Disability Status

1. *Are you deaf or do you have serious difficulty hearing?*
 - a. ☐ Yes
 - b. ☐ No
2. *Are you blind or do you have serious difficulty seeing, even when wearing glasses?*
 - a. ☐ Yes
 - b. ☐ No
3. *Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? (5 years old or older)*
 - a. ☐ Yes
 - b. ☐ No
4. *Do you have serious difficulty walking or climbing stairs? (5 years old or older)*
 - a. ☐ Yes
 - b. ☐ No
5. *Do you have difficulty dressing or bathing? (5 years old or older)*
 - a. ☐ Yes
 - b. ☐ No
6. *Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? (15 years old or older)*
 - a. ☐ Yes
 - b. ☐ No

Section 4302 of the ACA: LGBT Data Collection

- Status update
- Federal public health surveys collecting sexual orientation and/or gender identity
 - National Health Interview Survey (NHIS) – sexual orientation in 2013
 - Behavioral Risk Factor Surveillance System (BRFSS) – 25 states include at least 1 question on sexual orientation

Section 4302 of the ACA: LGBT Data Collection

- Suggested data collection
 - [Williams Institute](#)
 - [The Fenway Institute, Center for Population Research in LGBT Health](#)
 - Institute of Workshop (IOM)
 - [Workshop Description](#)
 - [Workshop Summary](#)

Section 10334 of the ACA

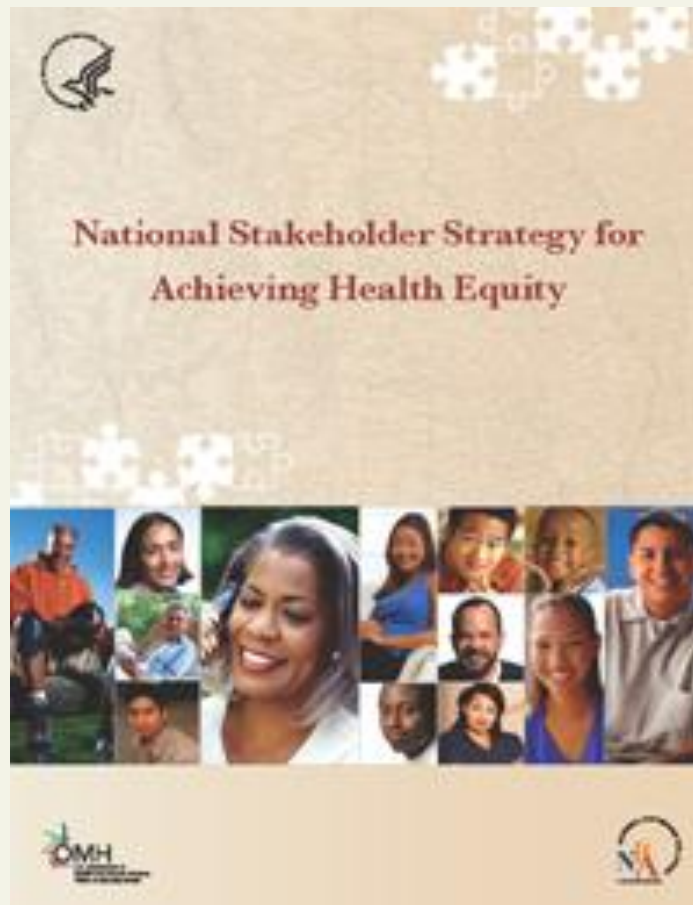
- Elevation of the NIH, National Center on Minority Health and Health Disparities to the National Institute on Minority Health and Health Disparities
- Creation of Offices of Minority Health in all of the federal health agencies
 - Department of Health and Human Services (DHHS)
 - Agency for Healthcare Research and Quality (AHRQ)
 - Centers for Disease Control and Prevention (CDC)
 - Centers for Medicare and Medicaid Services (CMS)
 - Food and Drug Administration (FDA)
 - Health Resources and Services Administration (HRSA)
 - Substance Abuse and Mental Health Services Administration (SAMHSA)



HHS Action Plan to Reduce Racial and Ethnic Health Disparities

**A NATION FREE OF DISPARITIES
IN HEALTH AND HEALTH CARE**





Aims

- **Awareness** - *Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations.*
- **Leadership** - *Strengthen and broaden leadership for addressing health disparities at all levels.*
- **Health System and Life Experience** - *Improve health and healthcare outcomes for racial, ethnic, and underserved populations.*

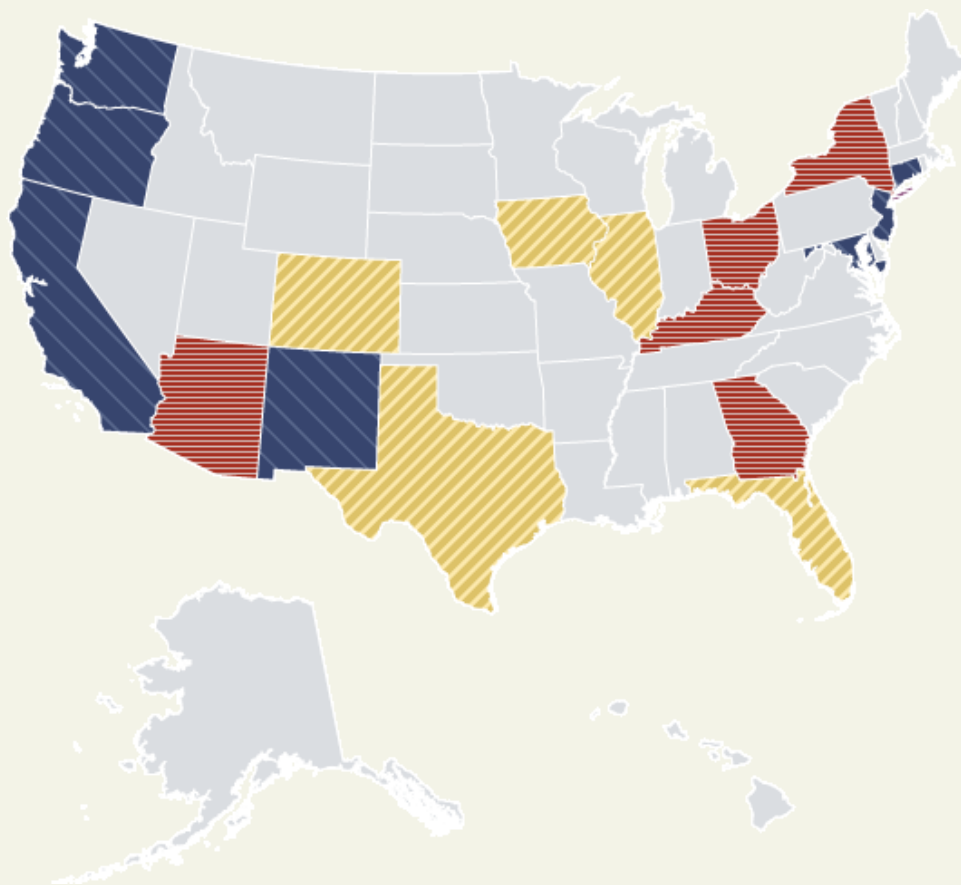
Aims

- **Cultural and Linguistic Competency** - *Improve cultural and linguistic competency and the diversity of the health-related workforce.*
- **Data, Research, and Evaluation** - *Improve data availability and coordination, utilization, and diffusion of research and evaluation outcomes.*

Federal and State Legislation, Mandates, and Regulatory Standards

- NCQA Patient-Centered Medical Home Recognition
- URAC Patient Centered Health Care Home Practice Achievement
- The Joint Commission Primary Care Medical Home Certification
- Accreditation Association for Ambulatory Health Care (AAAHC) Primary Care & Medical Home Accreditation

State Legislation on Cultural Competency Training



Blue - denotes legislation requiring (WA, CA, CT, NJ, NM) or strongly recommending (MD) cultural competence training that was signed into law.

Red - denotes legislation that was referred to committee and/or is currently under consideration.

Yellow - denotes legislation that died in committee or was vetoed.



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Health Equity: A Quality Issue



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Learning Objectives

- Define health and healthcare disparities as well as health equity
- Discuss changing U.S. and state demographics
- Describe federal and state legislation, mandates and regulatory standards related to health equity and quality
- Identify the business case for health equity
- Understand the National Healthcare Quality and National Healthcare Disparities Reports as resources to identify health disparities

Definitions

What are Health Disparities?

- “A particular type of **health difference** that is closely linked with **social, economic, and/or environmental disadvantage**. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their **racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location**; or other characteristics **historically linked to discrimination or exclusion**.”

Healthy People, 2020

Health Disparities Result from Complex Interactions among Multiple Factors



Adapted from King G and Williams DR. 1995. "Race and Health." In: *Society and Health*. Amick, Levine, Tarlov, Walsh (eds): Oxford Univ Press

Myths About Racial and Ethnic Health Disparities

- Caused by race differences in income/education
- Caused by lack of access to health care
- Caused by biological or genetic differences among race groups

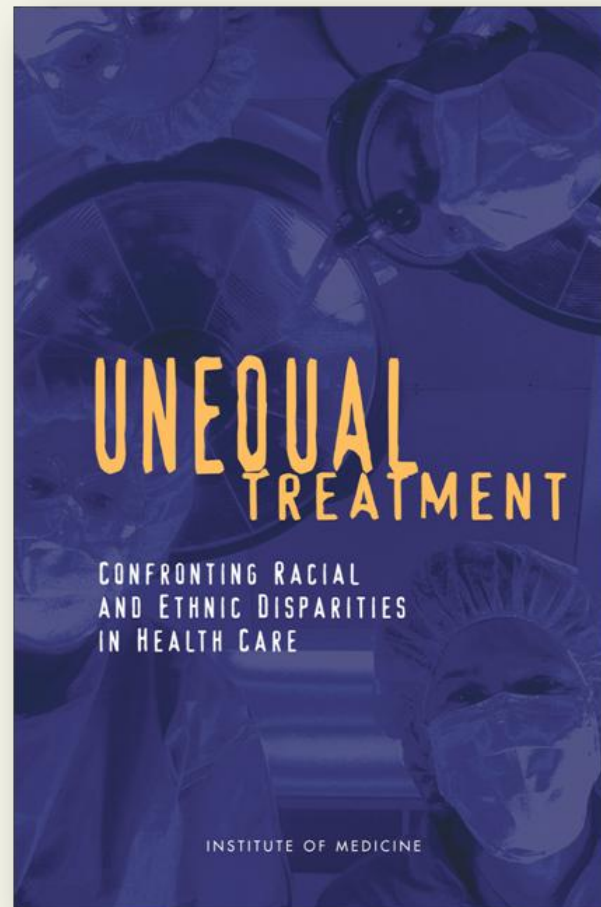
What are Healthcare Disparities?

- “Racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention” (*Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, 2003)
- “Differences or gaps in care experienced by one population compared with another population” (Agency for Healthcare Research and Quality, *National Healthcare Disparities Report*, 2009).

What is Health Equity?

- “Attainment of the highest level of health for all people. Requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.”

Unequal Treatment (2003)



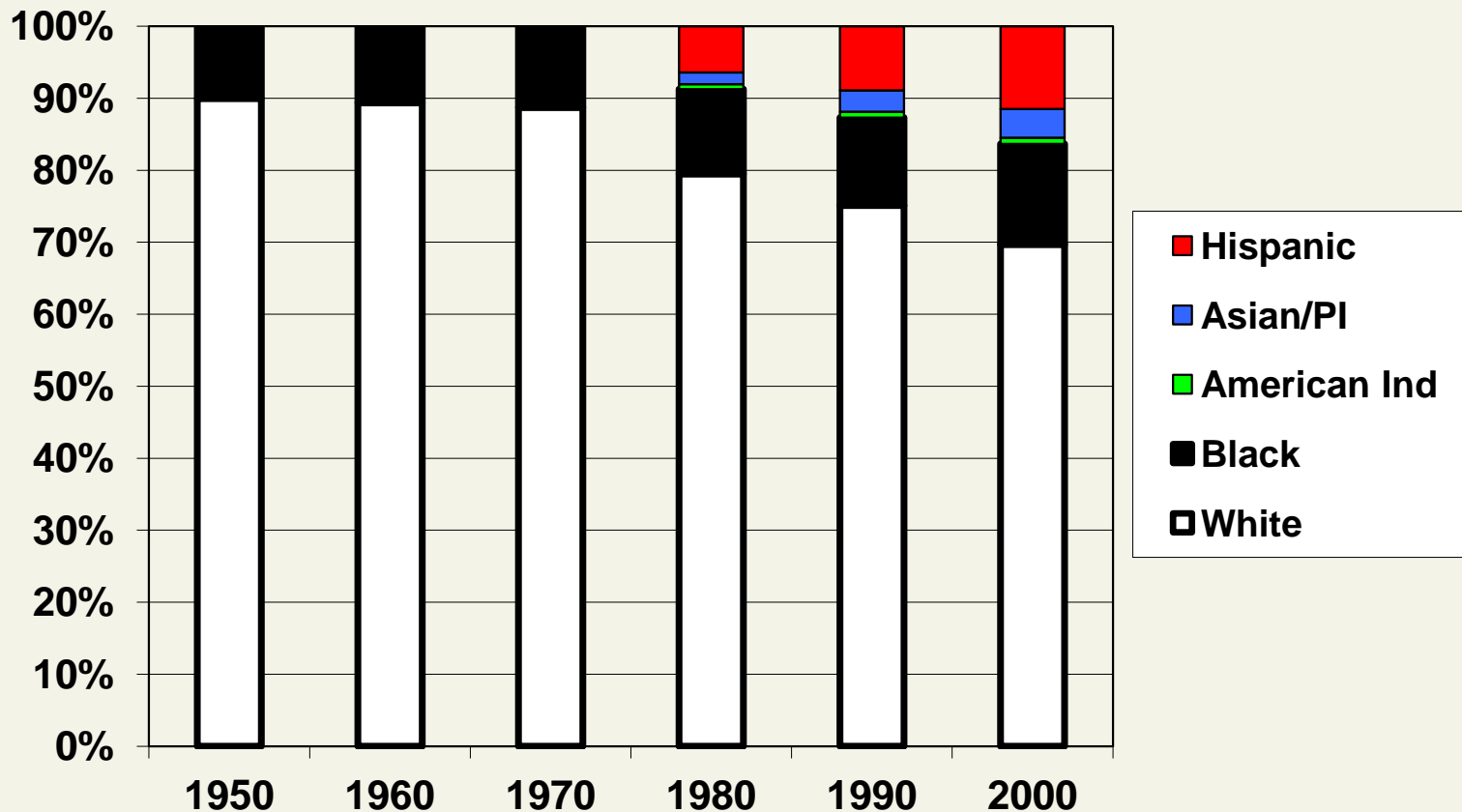
Unequal Treatment: Ten Years Later

Robert Wood Johnson Foundation, “Reducing Health Disparities: Where Are We Now?”

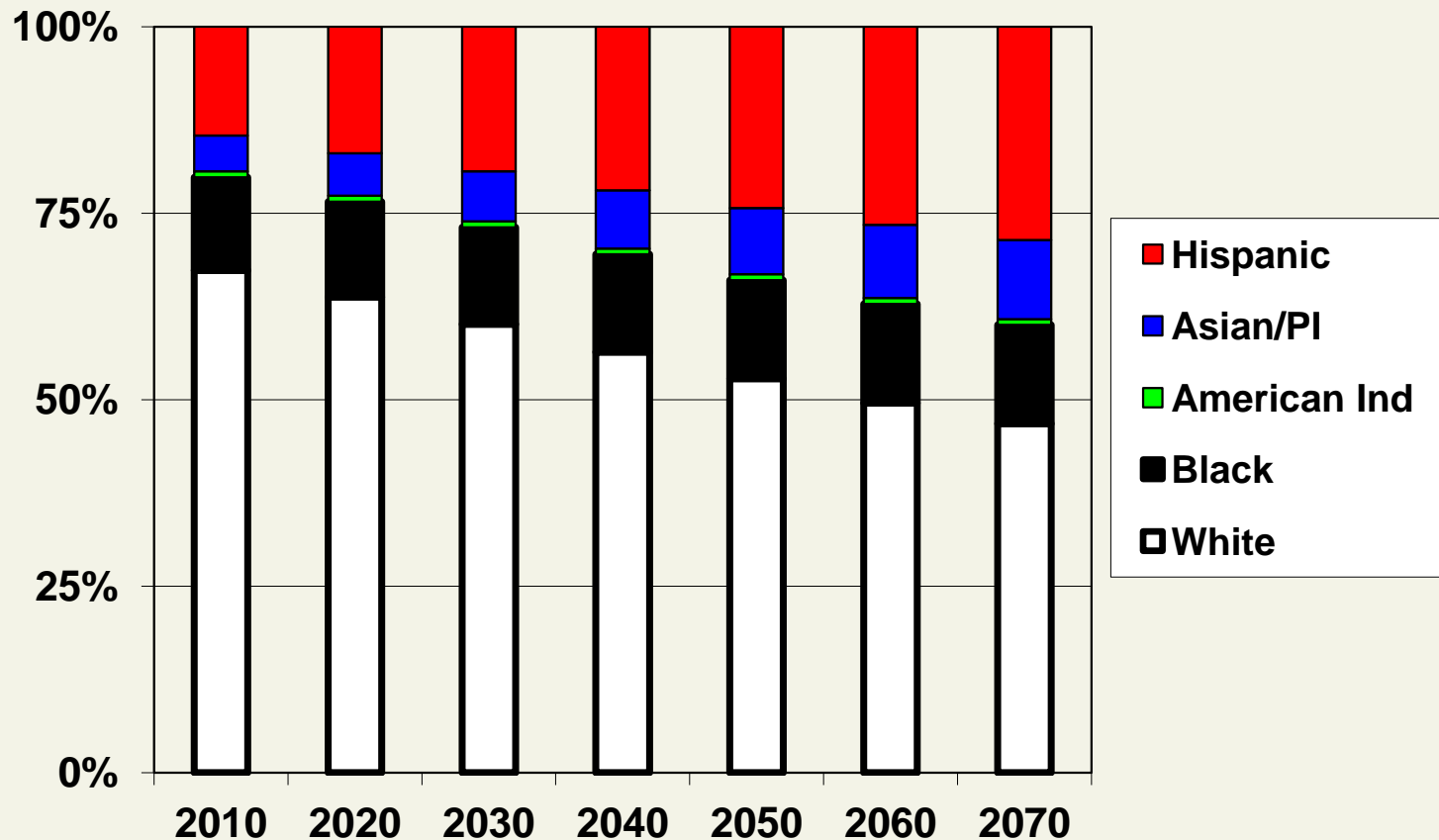
(March 2014)

U.S. and State Demographics

Changing Demographics: Percentage Resident Population by Race/Ethnicity, U.S. 1950-2000

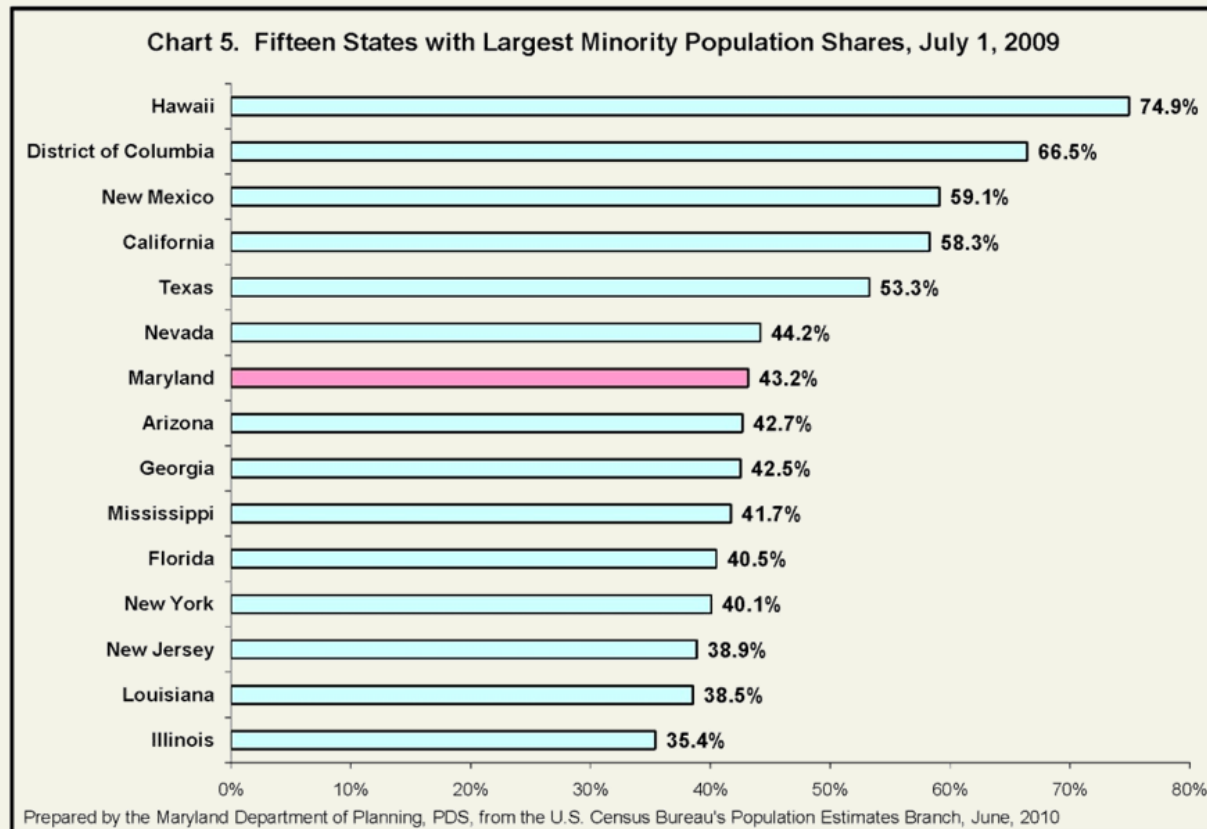


Changing Demographics: Projected Percentage Resident Population by Race/Ethnicity, U.S. 2010-2070



As of July 1, 2011, the U.S. Census Bureau estimated that 50.4% of the population younger than 1 was minority.

Changing State Demographics



- In 2008, four states—Hawaii (77.1%), California (60.3%), New Mexico (59.8%), and Texas (55.2%)—plus the District of Columbia (64.7%) were already majority minority.
- In the rest of the U.S., minorities constitute 36.6% of the population.

Changing State and Demographics

RACE	U.S. CENSUS (CT) 2000	U.S. CENSUS ACS SURVEY (CT) 2012
One Race		
White	81.6.%	82.0%
Black or African American	9.1%	11.2%
American Indian and Alaska Native	0.3%	0.5%
Asian	2.4%	4.2%
Native Hawaiian or Pacific Islander	--	0.1%
Some Other Race	4.3%	--
Two or More Races	2.2%	2.1%
ETHNICITY	U.S. CENSUS (CT) 2000	U.S. CENSUS ACS SURVEY (CT) 2012
Hispanic or Latino	9/4%	14.2%

Source: U.S. Census, 2000 and 2012 American Community Survey

Changing Demographics: Language Proficiency

- Increased number of foreign born residents
 - 12.7% of U.S. residents
 - 13.5% of Connecticut residents
- Increased numbers speak a language other than English at home
 - 20.6% of U.S. residents
 - 21.0% of Connecticut residents
- Increased numbers speak English less than "very well" and are considered limited English proficient (LEP)
 - 8.7% of U.S. residents

Changing Demographics: Language Proficiency

- Between 1990 and 2010, the U.S. LEP population increased **80%**.
- Between 1990 and 2010, the **10** states experiencing the greatest growth in their LEP populations were:
 - Nevada (398.2%), North Carolina (395.2%), Georgia (378.8%), Arkansas (311.5%), Tennessee (281.4%), Nebraska (242.2%), South Carolina (237.2%), Utah (235.2%), Washington (209.7%), and Alabama (202.1%).

Pandya, Chhandasi, Jeanne Batalova, and Margie McHugh. 2011. "Limited English Proficient Individuals in the United States: Number, Share, Growth, and Linguistic Diversity." Washington, DC: Migration Policy Institute.

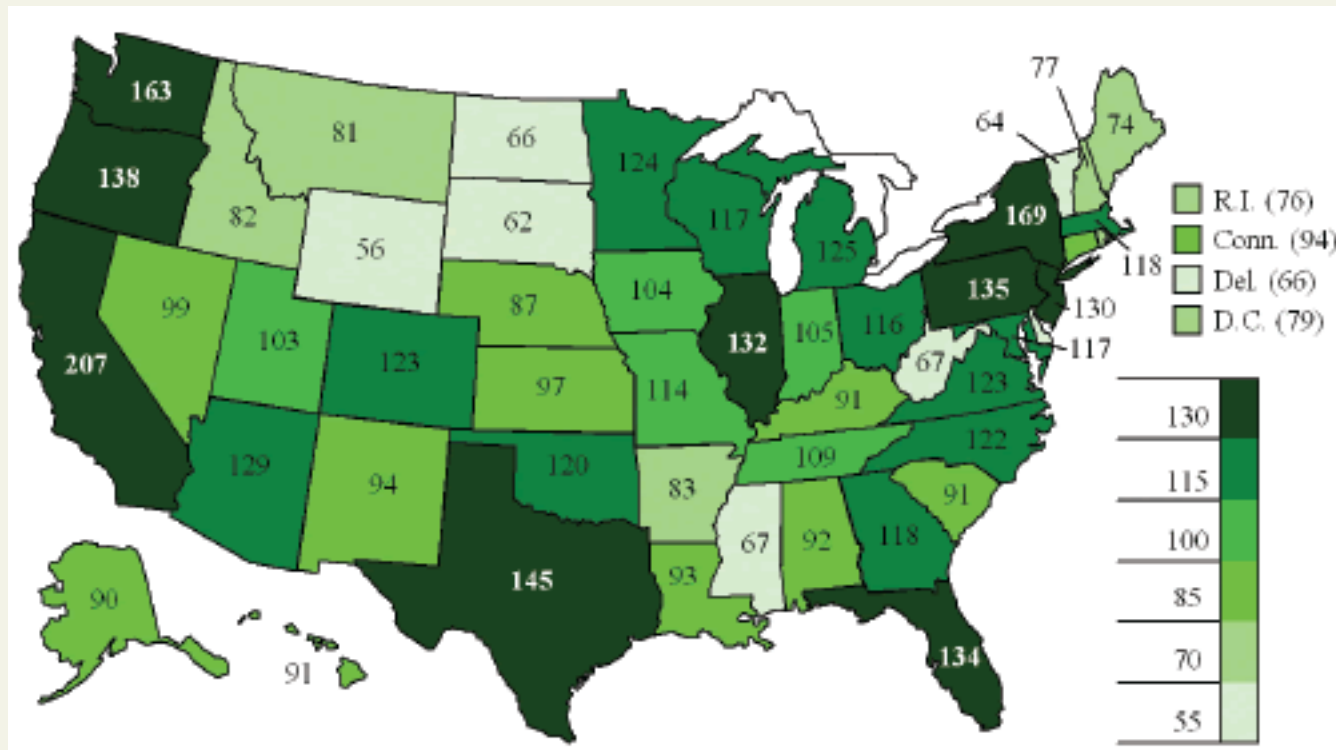
Changing Demographics: Language Proficiency

- In **8** states, at least **10%** of the overall population is already LEP.
 - California (19.8%), Texas (14.4%), New York (13.5%), New Jersey (12.5%), Nevada (12.3%), Florida (11.9%), Hawaii (11.8%), and Arizona (9.9%)

Pandya, Chhandasi, Jeanne Batalova, and Margie McHugh. 2011. "Limited English Proficient Individuals in the United States: Number, Share, Growth, and Linguistic Diversity." Washington, DC: Migration Policy Institute.

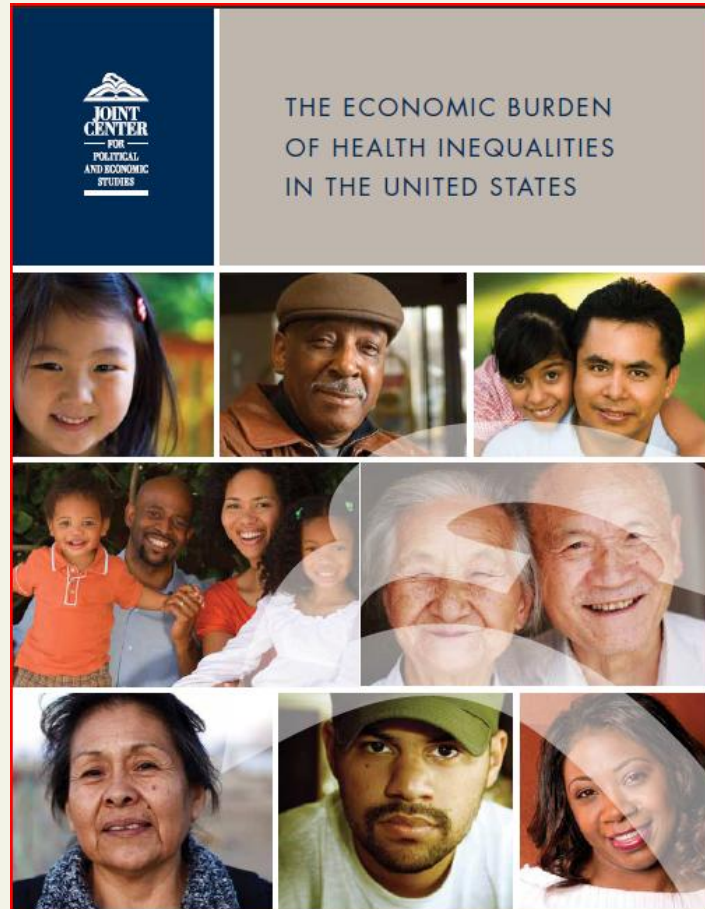
Number of Languages Spoken in Each State

U.S. Total = 322 languages



The Business Case

The Business Case: Economic Burden of Health Inequalities



- Direct Medical Care Costs \$229.4 billion for the years 2003-2006.
- Indirect Costs of disability and illness \$50.3 billion
- Cost of Premature Deaths were \$957.5 billion
- Total **\$1.24 trillion** (in 2008 inflation-adjusted dollars).

The Business Case: Influence on Healthcare Costs

- Poorer **patient experience** expressed on **HCAHPS** = reduced reimbursement
- **Avoidable readmissions** due to lack of culturally competent and health literate care

National Healthcare Quality and National Healthcare Disparities Reports

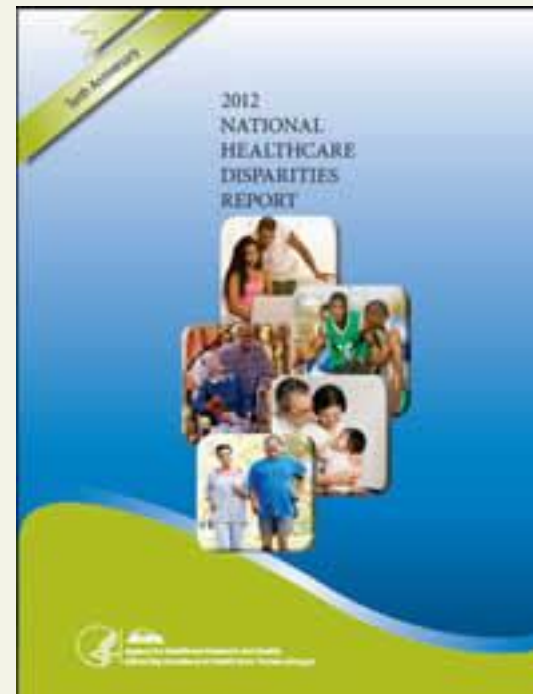
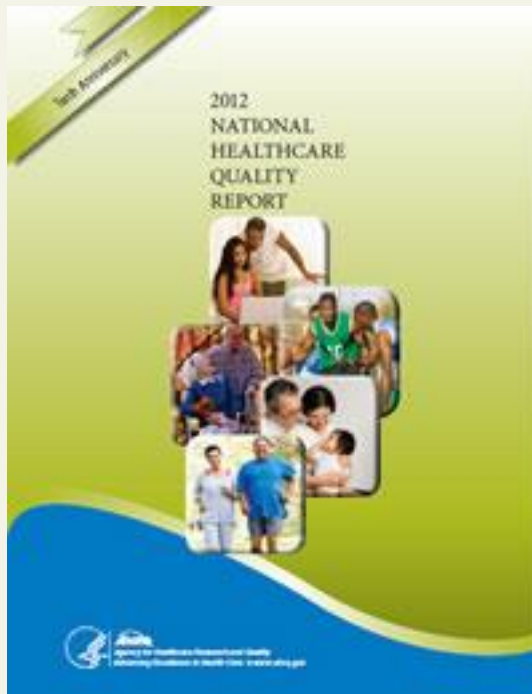
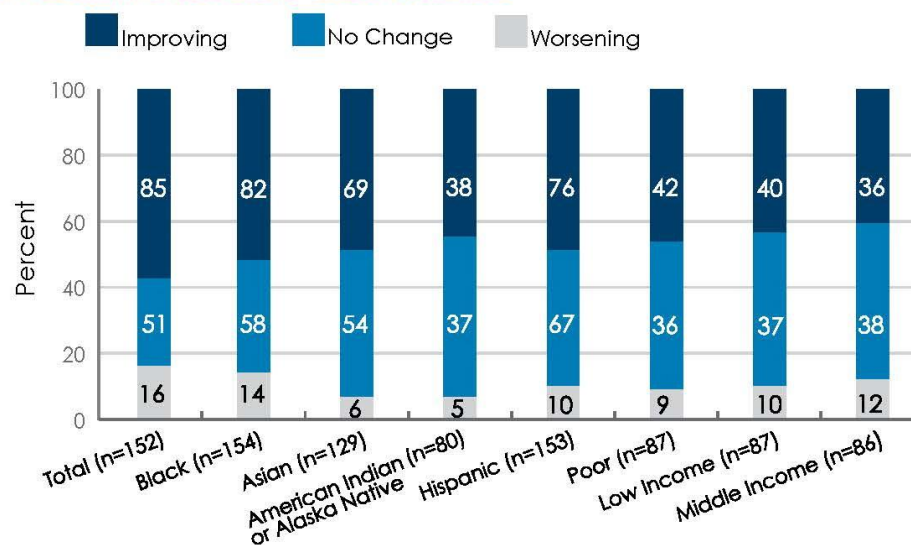


Exhibit 1. Number and Proportion of All Quality Measures that Are Improving, Not Changing, or Worsening, Overall and for Select Populations



Source: Agency for Healthcare Research and Quality. National Healthcare Disparities Report 2012.

Note: For each measure, the earliest and most recent data available to our team were analyzed; for the vast majority of measures, this represents trend data from 2000–2002 to 2008–2010.

Key: n = number of measures

Improving = Quality is going in a positive direction at an average annual rate of greater than 1% per year.

No Change = Quality is not changing or is changing at an average annual rate of less than 1% per year.

Worsening = Quality is going in a negative direction at an average annual rate of greater than 1% per year.

2011 Dashboard on Health Care Quality Compared to All States Overall Health Care Quality - Connecticut

State Snapshot

Hospital Equity Reports



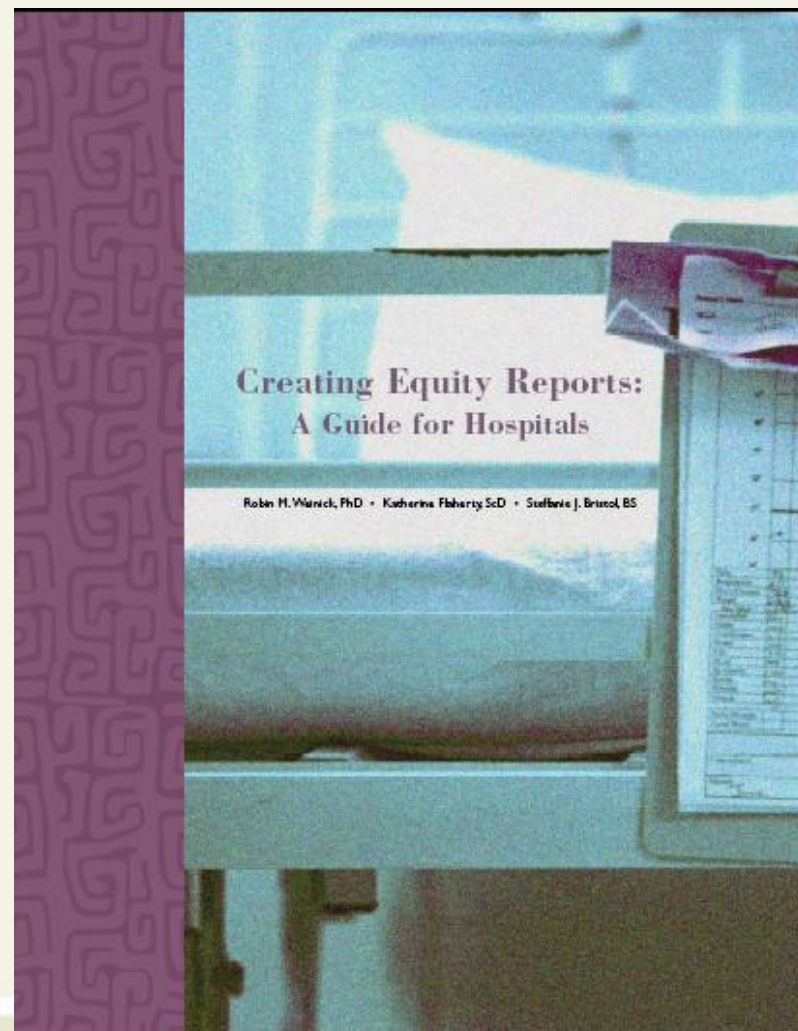
**Massachusetts General Hospital
Racial and Ethnic Disparities Dashboard
2007**

**Massachusetts General Hospital Committee on Racial and Ethnic
Disparities**

**Joseph R. Betancourt, M.D., M.P.H.
Joan Quinlan, M.P.H.
Co-Chairs**

**Massachusetts General Hospital Committee on Racial and Ethnic
Disparities Quality Subcommittee**

**Elizabeth A. Mort, M.D., M.P.H.
Chair
Sarah K. Lenz**



Mass General Performance Measures Dashboard

↑ Higher values are better performance

Measures	Comparison Group		Equity of Care
Heart Attack	Race: White	Race: Non-white	
Aspirin at Arrival	100%	100%	⬮
Aspirin at Discharge	100%	100%	⬮
Beta Blocker at Discharge	100%	100%	⬮
ACE-I/ARB at Discharge (AMI)	98%	100%	⬮
Time to Primary PCI of Less Than or Equal to 90 Minutes	88%	89%	⬮📄
Heart Failure	Race: White	Race: Non-white	
ACE-I/ARB at Discharge (HF)	96%	100%	⬮
Discharge Instructions (HF)	93%	87%	⬮⚡
LVF Assessment	100%	100%	⬮
Pneumonia	Race: White	Race: Non-white	
Timing of Blood Cultures	94%	92%	⬮
Selection of Antibiotics (PN)	93%	97%	⬮
Surgery	Race: White	Race: Non-white	
Antibiotics Received One Hour Prior to Surgery	98%	97%	⬮
Antibiotic Selection for Surgical Cases	98%	97%	⬮
Antibiotics Discontinued 24 Hours after Surgery	94%	91%	⬮

CONNECTICUT DATA

- Connecticut Commission on Health Equity Portal
- Connecticut Department of Public Health
 - “Enhancing Data Surveillance of Health Disparities in a State Public Health Agency Using Quality Improvement Processes” (2013)
 - “Moving Towards Health Equity in Connecticut,” (2013)
- Connecticut Department of Health, Office of Multicultural Health
- Connecticut State Health Improvement Plan

Maryland State Health Improvement Process (SHIP)

Maryland Office of Minority Health and Health Disparities

SOCIAL DETERMINANTS OF HEALTH: WHY IS YOUR ZIP CODE SUCH A STRONG PREDICTOR OF YOUR HEALTH?

Social Determinants of Health

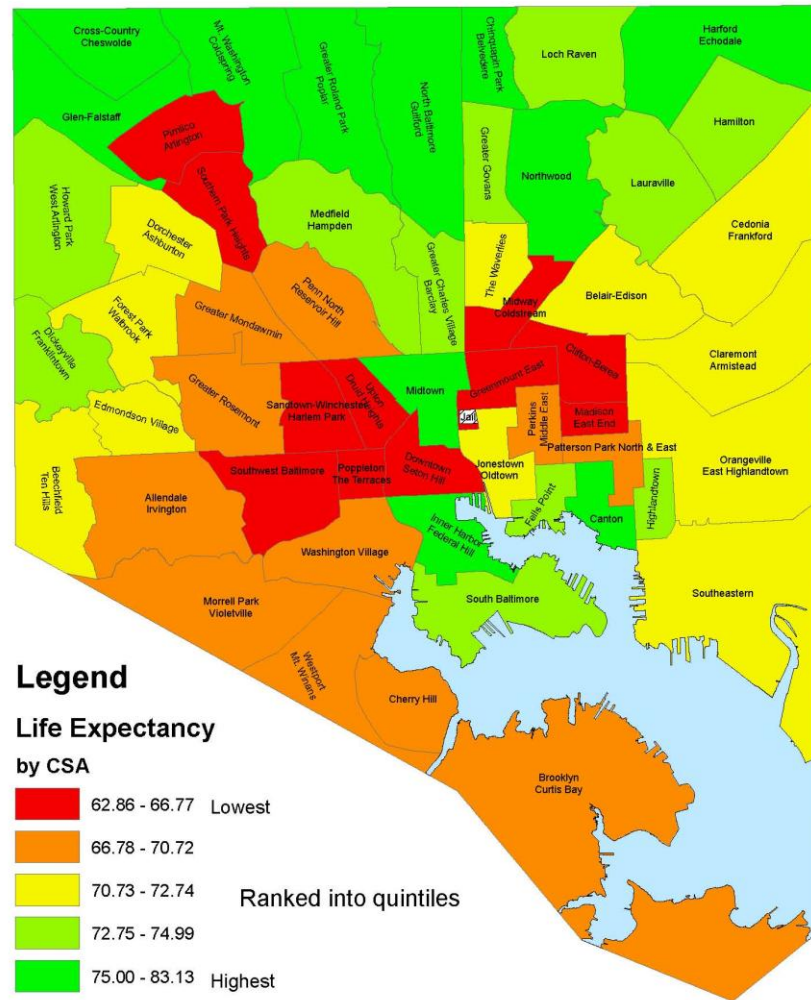
- “The social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.”

Avertable Deaths



2011 Baltimore City Life Expectancy by CSA

Life Expectancy

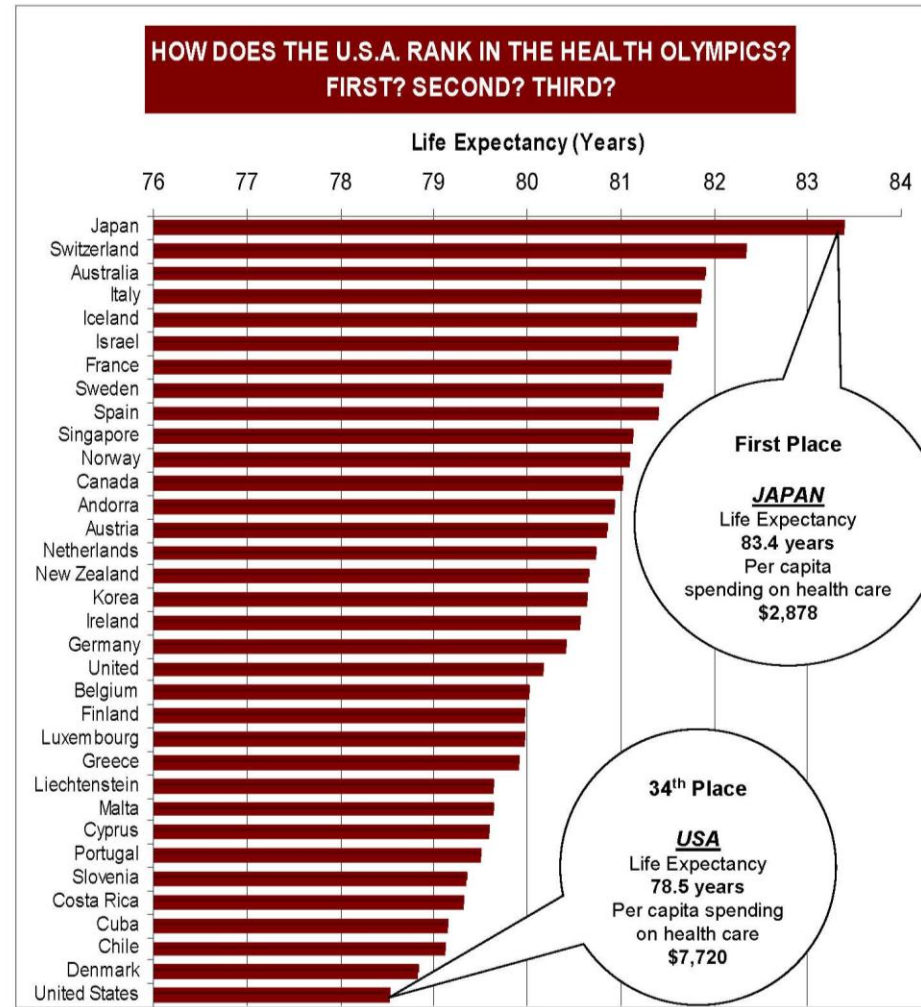


0 0.5 1 2 3 4 Miles

Prepared by: Baltimore City Health Department



2008 World Life Expectancy Rankings



**We spend twice as much per person on health care.
Yet our life expectancy is among the worst compared to other rich countries.**

Life expectancy data from: [Human Development Report of the United Nations Development Programme](#).
Health Expenditure data from: [2008 OECD Report](#).
Thanks to Dr. Stephen Bezruchka, MD for originating the Health Olympics.

INTERACTIVE EXERCISE: HEALTH EQUITY QUIZ

African American males in Harlem have a shorter life expectancy from age five than which of the following groups?

- A. Japanese**
- B. Bangladeshis**
- C. Cubans**
- D. Algerians living in Paris**
- E. All of the above**

ANSWER:
E. All of the above

The biggest killers of African American males in many poor, segregated urban neighborhoods are not violence nor drugs nor AIDS, but heart disease, stroke and other chronic diseases that cut men down in middle age.

On average, how many more supermarkets are there in predominantly white neighborhoods compared to predominantly Black and Latino neighborhoods?

- A. About the same**
- B. 2 times as many**
- C. 4 times as many**
- D. 6 times as many**

ANSWER:
C. 4 times

Predominantly Black and Latino neighborhoods have more fast-food franchises and liquor stores, yet often lack stores that offer fresh, affordable fruits and vegetables.

Generally speaking, which group has the best overall health in the U.S.?

- A. Recent Latino immigrants**
- B. Native-born whites**
- C. Native-born Latinos**
- D. Native-born Asian Americans**

ANSWER:

A. Recent Latino immigrants

Recent Latino immigrants have better health outcomes than other U.S. populations despite being, on average, poorer. However, the longer they live here, the worse they fare.

The most important factor behind the 30 year increase in U.S. life expectancy during the 20th century was:

- A. New drugs (like penicillin)**
- B. Social reforms (like wage and labor laws, housing codes, etc.)**
- C. The development of the modern hospital system**
- D. Migration from the countryside to the cities**
- E. More exercise and less smoking**

ANSWER:

B. Social Reforms

Researchers attribute much of our increase in life expectancy to social changes--better wages, housing, job security and working conditions, civil rights laws, sanitation and other protections that improved our health by improving our lives.

**Ireland, Sweden, France, Spain, Portugal
and the other western European nations all
mandate by law paid holidays and
vacations of 4 to 6 weeks.**

**How many days of paid vacation are
mandated by law in the U.S.?**

A. None

B. 10

C. 12

ANSWER:

A. None

The United States is the only rich country that does NOT guarantee any paid vacation NOR any paid sick days by law.

47% of private sector employees must choose between going to work sick and staying home and losing a day's pay.

Between 1980 and 2000 the gap in life expectancy between the most and least deprived counties in the U.S:

- A. Declined by 12%**
- B. Remained the same**
- C. Widened by 60%**

ANSWER: C

Widened by 60%

As economic inequality grew after 1980, so did the life expectancy gap between the rich and the rest of us.

In contrast, a recent study (Krieger et al) showed that premature death and infant mortality gaps narrowed between 1966 and 1980.

a
four-hour
documentary
series
exploring
America's
racial and
socioeconomic
inequities
in health



UNNATURAL CAUSES

...is inequality making us sick?

**A documentary series & public impact
campaign**

www.unnaturalcauses.org

**Produced by California Newsreel with Vital Pictures
Presented on PBS by the National Minority Consortia of Public Television
Impact Campaign in association with the Joint Center Health Policy Institute**



*Hopkins Center for
Health Disparities Solutions*

DOCUMENTARY TRAILER

Question to keep in mind while viewing the episode

- Why are zip code and street address good predictors of your health?

Episode 5: Living in Disadvantaged Neighborhoods is Bad for Your Health

Video Clip

Discussion

- Why are zip code and street address good predictors of your health?

INTERACTIVE EXERCISE: **A TALE OF TWO SMOKERS**

Common perceptions about health outcomes and social inequities

1. Personal responsibility
2. Unfortunate, but not unjust
3. Nothing can be done.

For further information, please contact:

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Q&A

